RYAN WHITE CARE ACT
2001 DENTAL REIMBURSEMENT PROGRAM

APPLICATION FORM

OMB No. 0915-0151
Expires: January 31, 2002

Division of Community-Based Programs
HIV/AIDS Bureau
Health Resources and Services Administration
Parklawn Building, Room 7A-30
5600 Fishers Lane
Rockville, Maryland 20857

Please refer to the 2001 Dental Reimbursement Program Application Instructions for a description of each section and item.

PROGRAM INFORMATION

1. Institution/Program Information

Name_____

_____

Address *(include street, city, state, and ZIP code)*

Federal Tax ID # __ __ - __ __ __ __ __ __ __

2. Person authorized to sign for the institution:

Name_____

_____

Title/Position_____

Address *(if different from address in #1)*

Signature_____

3. Contact person (dentist or dental hygienist) most closely connected to the provision of services for which reimbursement is requested:

This individual will be notified of funding and will be the contact person for all Dental Reimbursement Program communications.

Name_____

_____

Title/Position_____

Address *(if different from address in #1)*

Telephone: (__ __ __) __ __ __-__ __ __ __

Fax: (__ __ __) __ __ __-__ __ __ __

Pager: (__ __ __) __ __ __-__ __ __ __

Email address:_____

4. G Check this box if the principal contact person in #3 would like to receive bimonthly updates on technical assistance and primary care related to the Ryan White CARE Act.

The HIV/AIDS Bureau distributes this information by email ONLY.

5. Alternate contact person responsible for providing the services for which reimbursement is requested:

This individual will be contacted if the person identified in #3 cannot be reached.

Name_____

_____

Title/Position_____

Address *(if different from address in #1)*

Telephone: (__ __ __) __ __ __-__ __ __ __

Fax: (__ __ __) __ __ __-__ __ __ __

Pager: (__ __ __) __ __ __-__ __ __ __

Email address:_____

6. Contact person *(if different from #3)* responsible for verifying and submitting data contained in this application:

These data, provided as part of the Federal program, are subject to audit.

Name_____

_____

Title/Position_____

Address *(if different from address in #1)*

Telephone: (__ __ __) __ __ __-__ __ __ __

Fax: (__ __ __) __ __ __-__ __ __ __

Pager: (__ __ __) __ __ __-__ __ __ __

Email address:_____

PATIENT DEMOGRAPHICS AND SERVICES

Avoid reporting in the "unknown" category whenever possible.

7. Total number of unduplicated patients with HIV treated through the dental school/postdoctoral dental program/ dental hygiene program:

☐

Indicate direct counts of patients with HIV. Estimates or calculations using sampling methodology are not permitted.

8. Number of patients with HIV by gender:

☐ Males

☐ Females

☐ Transgender

☐ Unknown/unreported

9. Number of patients who were *pregnant women* with HIV:

☐

☐ Unknown/unreported (Reason why: _____ _____)

10. Number of patients with HIV by ethnicity:

Ethnicity	Number of Patients with HIV
Hispanic or Latino/a	
Non-Hispanic or Latino/a	
Unknown/unreported	

11. Number of patients with HIV by race:

Race	Number of Patients with HIV
White	
Black or African-American	
Asian	
Native Hawaiian or other Pacific Islander	
American Indian or Alaska Native	
Multiple races	
Other [specify_____ _____]	
Unknown/unreported	

12. Number of patients with HIV by age:

Age	Number of Patients with HIV
0–12 years	
13–19 years	
20–24 years	
25–44 years	
45 years and older	
Unknown	

13. Number of visits for each type of service made by patients reported in Item #7:

Type of Service	Number of Visits
Diagnostic	
Preventive	
Oral health education/health promotion	
Nutrition counseling	
Tobacco intervention/cessation	
Oral Medicine/Oral Pathology	
Restorative	
Periodontics	
Prosthodontics	
Oral Surgery	
Endodontics	
Other [specify_____ _____]	

REIMBURSEMENT AND FUNDING

Avoid reporting in the "unknown" category whenever possible.

14. Of the total number of unduplicated patients with HIV (Item #7):

Number of patients who received oral health care with **NO** reimbursement source	
Number of patients who received oral health care with **FULL or PARTIAL** reimbursement source	
Number of patients whose reimbursement status was unknown	

15. Indicate the number of patients with HIV whose oral health care was FULLY or PARTIALLY reimbursed by each of the following sources, and the amount of reimbursement received:

Reimbursement Source	Number of Patients with HIV	Reimbursement received ($$)
Medicaid (HMO/managed care)		
Medicaid (non-HMO/ non-managed care)		
Medicare		
Other public insurance (CHAMPUS, VA, etc.)		
Private insurance, including HMO/managed care		
Other [specify _____ _____]		
Unknown		

16a. **Total unreimbursed costs of oral health care provided to patients with HIV:**

$

16b. As a separate attachment, please provide a concise description of the methods used to calculate Item #16a.

17. Specify how the dental reimbursement funds will be used within your dental school/postdoctoral dental program/dental hygiene program: *(check all options that apply)*

- G Direct patient services (e.g., provider/faculty salaries)
- G Patient education
- G Curriculum development
- G Student education/training
- G Staff education/training
- G Clinic staff salary/support
- G Equipment/Instruments/Supplies
- G General operations
- G Other [specify _____)

18a. Did your institution identified in #1 receive any other Ryan White CARE Act funding (not only for oral health care) during the reporting year?

- G Yes *(please complete Item #18b)*
- G No *(please skip to Item #19)*

18b. Total funds your institution received from these Ryan White CARE Act grant programs to provide any HIV-related services:

CARE Act Title/Program	Amount Received
Title I	
Title II	
Title III	
Title IV	
Special Projects of National Significance (SPNS)	
AIDS Education and Training Centers (AETCs)	

Complete the following narratives as a separate attachment:

19. List and concisely describe the sites where your dental school/ postdoctoral dental program/dental hygiene program provides oral health services to patients with HIV. Also, answer the following questions: Do your students or residents provide care in community-based facilities? Are such facilities organizational components of your institution or are they separate organizations?

20. Concisely describe working relationships that your dental school/postdoctoral dental program/dental hygiene program has established with the Ryan White CARE Act programs listed in Item #18b, including Title I HIV planning councils and Title II HIV consortia. Describe how your program has been working to maximize coordination, integration, and effective linkages among Ryan White CARE Act programs. Formal letters of agreement and memoranda of understanding may be included as an appendix, but they are not required.

21. Concisely describe how your dental school/postdoctoral dental program/dental hygiene program has been involved in the development of the Statewide Coordinated Statement of Need (SCSN).

22. Concisely describe any additional ways your dental school/ postdoctoral dental program/dental hygiene program conducts outreach to persons with HIV to increase awareness of the availability of oral health services, or builds community links with program managers and providers working with this population.

23. Concisely describe any special strengths or unique capabilities of your dental school/ postdoctoral dental program/dental hygiene program with respect to providing oral health care for patients with HIV (facilities, hours of operation, support services, skills, or staff). Responses might include information such as evening and weekend clinic hours, onsite participation in clinical trials, provider or staff diversity, special patient education programs, child-care services, language-translation services, transportation services, and so on.

Responses to #20–#23 are voluntary, but are strongly encouraged.

Please enclose the narrative responses to items #16b and #19–#23 as a separate attachment.